UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF LOUISIANA

FELONY

BILL OF INFORMATION FOR CONSPIRACY TO COMMIT HEALTH CARE FRAUD AND ASSET FORFEITURE

UNITED STATES OF AMERICA	*	**CRIMINAL ACTION NUMBER**
VERSUS	*	**SECTION:**
ANTHONY STEPHEN JASE, MD	*	**VIOLATION:** *18 USC §1349* *18 USC §982(a)*

* * *

The United States Attorney charges that:

COUNT 1

A. AT ALL TIMES MATERIAL HEREIN:

Medicare

1. The Medicare Program ("Medicare") was a federal program that provided free or below-cost health care benefits to certain individuals, primarily the elderly, blind, and disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the United States Department of Health and Human Services ("HHS"). Individuals who received benefits under Medicare were often referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program" as defined by 18 U.S.C. § 24(b).

3. Medicare Part B helped pay for certain physician services, outpatient and other services, including durable medical equipment ("DME") that was medically necessary and was ordered by licensed medical doctors or other qualified health care providers. DME was

equipment designed for repeated use and for a medical purpose, such as a power wheelchair, accessories associated with power wheelchairs (such as batteries, seat cushions, and spare tires), and orthotics (such as foot, ankle, knee, wrist, elbow, back and shoulder braces).

Medicare Billing Procedures

4. In order to bill Medicare for DME equipment, a DME supplier had to be an approved Medicare supplier. The DME supplier obtained this approval by submitting an application to the DME regional carrier. Upon approval of the application, the DME supplier was issued a "supplier number," which was used to submit claims for payment to Medicare for the cost of DME supplied to beneficiaries.

5. To receive payment from Medicare, a DME company, using its supplier number, submitted a health insurance claim form, known as a CMS-1500. Medicare permitted DME companies to submit a CMS-1500 electronically or by way of a paper claim form. The CMS-1500 required DME companies to provide certain information, including: (a) the Medicare beneficiary's name; (b) the Medicare beneficiary's identification number; © the name and identification number of the doctor who ordered the item or service that was the subject of the claim; (d) the health care benefit, item, or service that was supplied or provided to the beneficiary; (e) the billing code for the benefit, item, or service; and (f) the date on which the benefit, item or service was provided. When the claim was submitted, the provider certified that the contents of the form were true, correct, and complete, and that the form was prepared in compliance with the laws and regulations governing the Medicare program.

6. DME suppliers submitted claims to Medicare using the Healthcare Common Procedure Coding System ("HCPCS"), a series of five-digit codes that corresponded to various types of medical goods, items, and services.

7. For Louisiana beneficiaries, Medicare Part B insurance covering DME and related health care benefits, items, and services was administered by Palmetto Government Benefit Administrators ("Palmetto") through June 1, 2007, and thereafter CIGNA Government Services ("CIGNA"), pursuant to contracts with HHS. Palmetto and CIGNA received, adjudicated, and paid the claims submitted to them by Medicare beneficiaries, physicians, or suppliers of health care items and services.

8. Medicare, through Palmetto and CIGNA, generally paid a substantial portion of the cost of the DME or related health care benefit, item, or service if it was medically necessary and ordered by a licensed, qualified health care provider.

9. Payments under Medicare Part B were often made directly to the DME company. For this to occur, the beneficiary assigned the right of payment to the DME company or other health care provider. Once such an assignment took place, the DME company assumed the responsibility for submitting claims to, and receiving payments from, Medicare.

Power Mobility Devices

10. Under Medicare rules, Medicare Part B paid for the cost of a power mobility device (PMD) supplied to a beneficiary when the patient had a mobility limitation that significantly impaired his/her ability to participate in one or more mobility-related activities of daily living; the patient's mobility limitation could not be resolved sufficiently and safely by the use of an appropriately fitted cane or walker; and the patient did not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform activities of daily living.

11. In order for a DME supplier to be paid for the cost of a PMD, Medicare required a thorough face-to-face visit with the treating physician prior to dispensing any PMD. The face-to-

face visit had to be completed before the written order was received. A PMD could not be delivered based on a verbal order. If the supplier delivered the item prior to receipt of a written order, the PMD would be denied as non-covered. If the written order was not obtained prior to delivery, payment would not be made even if a written order was subsequently obtained. The face-to-face examination report ("examination report") was part of the documentation required to substantiate a DME provider's claim submission for delivery of a PMD to a Medicare beneficiary, along with a valid written order, detailed product description, home assessment, patient authorization, and proof of delivery.

Arthritis Kits

12. Certain orthotic devices packaged together were known in the DME industry as an "Arthritis Kit." Arthritis Kit was neither an official medical term nor a term used by Medicare. The term was commonly used by individuals working within the DME industry to refer to a package of items that included back, elbow, knee, ankle, wrist and shoulder braces, gloves and a heating pad or a heat lamp. Each individual item in the Arthritis Kit was Medicare reimbursable if it was medically necessary, ordered by a physician, and actually delivered to the Medicare beneficiary.

The Defendant

13. "DME COMPANY" (not identified by its' actual name in this Bill of Information) was a Louisiana corporation primarily in the business of providing PMDs, orthotics, and other DME to Medicare beneficiaries. DME COMPANY had a Medicare supplier number and was eligible to receive reimbursement from Medicare for services and equipment that DME COMPANY provided to beneficiaries, provided that such equipment was medically necessary, had been ordered by a physician, and the equipment provided met the description of the equipment billed to Medicare.

14. Defendant, **ANTHONY STEPHEN JASE ("JASE")** was a licensed medical doctor authorized to practice medicine in Louisiana. **JASE** operated a medical practice in New Orleans, Louisiana.

15. Unindicted Co-conspirator 1 ("MARKETER") was a marketer, or "recruiter" for DME COMPANY.

16. Unindicted Co-conspirator 2 ("OWNER") owned, managed, and made financial decisions for DME COMPANY.

B. THE CONSPIRACY:

Beginning in or about March 2004, and continuing until in or about February 2009, in the Eastern District of Louisiana and elsewhere, the defendant, **ANTHONY STEPHEN JASE,** and others known and unknown to the United States Attorney, willfully and knowingly did combine, conspire, confederate and agree together and with each other to knowingly and willfully execute and attempt to execute a scheme and artifice to defraud Medicare and to obtain, by means of false and fraudulent pretenses, representations, and promises, money owned by and under the custody and control of Medicare in connection with the delivery of and payment for health care benefits and services, in violation of Title 18, United States Code, Section 1347.

C. OBJECT OF THE CONSPIRACY:

MARKETER identified Medicare beneficiaries willing to receive DME, regardless of whether or not the equipment was useful or necessary. **JASE** signed documentation, including the examination report, presented to him by MARKETER which prescribed DME for those Medicare beneficiaries even though they were not his patients. OWNER then billed Medicare for the DME and paid MARKETER a kickback based on the Medicare reimbursement value paid to DME COMPANY.

D. WAYS AND MEANS TO ACCOMPLISH THE CONSPIRACY:

Among the ways and means by which **JASE** carried out the conspiracy was that the OWNER paid MARKETER to find and locate physicians willing to certify patients for PMD, PMD accessories and other orthotic devices. **JASE** signed prescriptions authorizing PMD and other DME presented to him by MARKETER. After **JASE** gave MARKETER pre-signed, undated, blank examination reports and Physician's Orders, MARKETER had the ability to freely provide PMDs and DME to anyone MARKETER could locate willing to receive such equipment. MARKETER falsified the pre-signed, undated examination reports and Physician's Orders by adding misleading information to make the beneficiaries appear to qualify for a PMD when the beneficiaries did not need or otherwise qualify for PMDs or other DME.

JASE and MARKETER well knew that **JASE** had not seen or medically treated the vast majority of the beneficiaries for which he was prescribing and that he had no knowledge of their DME needs or physical condition.

Medicare paid DME COMPANY approximately $230,963.26 for PMD and other DME authorized by **JASE** through MARKETER.

E. OVERT ACTS:

In furtherance of the conspiracy and to accomplish the purposes thereof, Defendant **ANTHONY STEPHEN JASE**, and others known and unknown to the United States Attorney, committed the following overt acts, among others, in the Eastern District of Louisiana:

1. On about July 11, 2008, DME COMPANY, using a falsified examination report and Physician's Order provided by **JASE**, submitted claims to Medicare in the amount of $7,554.52 for Medicare beneficiary RoAd to receive a PMD and DME.

2. On about July 17, 2008, Medicare paid DME COMPANY approximately $5,905.72 for PMD and DME billed on behalf of Medicare beneficiary RoAd on July 11, 2008.

All in violation of Title 18, United States Code, Section 1349.

ASSET FORFEITURE

The allegations contained in Count 1 are hereby realleged and incorporated by reference for the purpose of alleging forfeiture to the United States of America pursuant to the provisions of Title 18, United States Code, Section 982.

As a result of the offense alleged in Count 1, the defendant **ANTHONY STEPHEN JASE, M.D.**, shall forfeit to the United States pursuant to Title 18, United States Code, Section 982(a)(7), any and all property, real and personal, that constitutes or is derived directly or indirectly, from gross proceeds traceable to the commission of the offenses as a result of the violation of Title 18, United States Code, Section1349, which is a Federal Health Care offense within the meaning of Title 18, United States Code, Section 24.

If any of the property subject to forfeiture, as a result of any act or omission of the defendant,

1. cannot be located upon the exercise of due diligence;
2. has been transferred, sold to, or deposited with, a third person;
3. has been placed beyond the jurisdiction of the Court;
4. has been substantially diminished in value; or
5. has been commingled with other property which cannot be subdivided without difficulty;

it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p) as

incorporated by Title 18, United States Code, Section 982(b), to seek forfeiture of any other property of said defendant up to the value of the above forfeitable property;

All in violation of Title 18, United States Code, Section 982(a).

JIM LETTEN
UNITED STATES ATTORNEY
Louisiana Bar Roll No. 8517

JAN MASELLI MANN
First Assistant United States Attorney
Louisiana Bar Roll No. 9020

PATRICE HARRIS SULLIVAN
Assistant United States Attorney
Bar Roll No. 14987

New Orleans, Louisiana
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